Testimony before the Health Policy Commission, March 25, 2015

Mr. Chairman, Members of the Commission:

I'm sure that you are an organization of dedicated public servants, and it's an honor to testify before you today.

My name is David A. Sherman, and I've been an ICU nurse for almost 20 years, certified in the specialty of critical care nursing and the subspecialty of cardiac medicine. Some of my work has been published in peer-reviewed journals in my field, and I've given talks at institutions in Massachusetts and elsewhere, including Harvard Medical School. My employment is at a hospital north of Boston.

My first concern with the proposed regulations is to make them consistent with the law as passed. From the beginning (under General Provisions--8.01), the regulations refer to a "ratio of one-to-one or one-to-two," but ignore the statutory language making that differentiation based on patient stability. These references should be changed consistent with the law as passed, throughout.

In fact there is strong evidence that the legislative intent was a default staffing ratio of 1:1, with an occasional option of one nurse to two patients if a patient became stable. This intent is clear from Sen. Rosenberg's introduction of the bill on the Senate floor (https://www.youtube.com/watch?v=GWU7DMmzmaU. Accessed March 24, 2015). From a nursing care point of view, it would be appropriate to add language to support this standard to the regulations.

An important addition, necessary to make the law workable, would be to specify that retaliation against staff nurses who advocate 1:1 status, against management, or who testify at these and similar hearings, is forbidden and punishable.

As a nurse who has seen patients deteriorate quickly, I recommend a change to 8.05(3) to require assessment of stability every 4 hours, or more often if there is a substantive change in patient condition. In fact, because a nurse's shift may be 8, 12, or sometimes even 16 hours, the reference in 8.05(3) to assessing during a "Shift" is quite ambiguous.

As I see it, the Acuity Tool would be most specifically governed by 8.07(4). ICU-level care continues to evolve, demanding more time from nurses as it does, almost as I speak. I want to make clear at the outset that the evolution I will discuss here is a good thing--we see better patient outcomes from the examples I'll use--and I hope that the Commission will support it in every way. Evidence shows, for example, that early mobility can result in better outcomes for populations of critically ill patients. Even the bed bath has become more complex as we shift back from the relatively quick "bath-in-a-bag" that the manufacturers told us requires no rinse or dry, to the more complex antiseptic baths using chlorhexidine which does. These are two time-consuming examples of activities of daily living, interestingly enough both very low-tech and occurring throughout inpatient care. I'm not discussing here the high-tech work that is unique to ICUs.

Despite the relative stability of any patient assignment, assisting with activities of daily living takes a critical care nurse away from other necessary critical care tasks (Stability and acuity are not the only patient determinants of staff availability for emergent situations). A stable patient who requires total assist with bathing, may now need 35-40 minutes for it, two patients obviously twice as long. 8.07(4) briefly mentions "therapeutic supports," and patient "functional ability," but would not require the Acuity Tool to specifically capture assistance with activities of daily living; such a Tool should.

Other often time-consuming tasks include the fundamental nursing task of patient advocacy. I classify patient advocacy as often being part of interdisciplinary communication, and the evidence is growing that that communication is associated with better patient outcomes. The Tool should also be required to capture that advocacy (The "need for care coordination" in 8.07 (4) (b) does not). In our era of family-centered care, in which family satisfaction can effectively in part determine hospital reimbursements, we nurses now spend an increasing amount of time taking care of families. 8.07 (4) (b) 2 mentions family communication skills and cultural differences as it should, but the regulation should also require a Tool to capture the amount of time we spend answering family questions in person and/or on the phone (often away from the patient), as well as simply making them comfortable. Again, staff availability for emergent situations is governed by more than patient stability or acuity.

Lastly regarding 8.07, of all the body systems mentioned, the vascular is omitted, thus missing the acuity of patients who may have stable cardiac systems, but require frequent vascular checks due to fluoroscopic intravascular procedures. Acuity Tools should be required to include the vascular system, as well as the psychosocial system. It is also reasonable to include substance abuse issues here.

Use of barrier precautions is more and more frequent because of the growing prevalence of infectious diseases that require these measures to prevent their spread, such as MRSA, C diff, and the newer carbipenem-resistant enterobacteriaceae species. Added up through a nurse's shift, repeated gowning, gloving, and hand-washing in addition to hand sanitizing take a significant amount of time away from other vital nursing tasks--again this is a low-tech part of ICU-level care. Infectious status should also be added to 8.07 (4).

8.10's reporting requirements should legitimately also require reporting on disagreements on staffing between assigned Staff Nurses and Nurse Managers and how they were resolved, preferably instance by instance as opposed to statistical form, for better data accessibility.

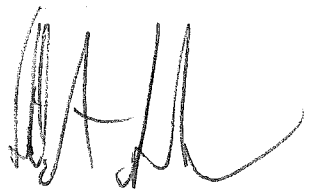
Consistent with the factor of family-centered care which I mentioned earlier, it would be appropriate to require that the statutory staffing requirement be posted in family waiting areas and perhaps even in patient rooms.

Lastly, my reading of statute 111 MGL 231 is that it is in effect now, even while these regulations are being drafted. I hope that the Commission can issue guidance to this effect to hospitals.

I'd like to thank the Commission for the public service they provide and for hearing my testimony today. I mentioned a moment ago my hope that the Commission will support the evolution of critical care nursing that I describe. Keeping the new and important Safe Staffing law solid would be part of that support. I hope the changes I recommend, springing from my perspective "in the trenches," will be adopted in order to do so.

I'm happy to answer any questions you may have.

Respectfully submitted,



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